Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

TO QUALIFY, YOU MUST BE ABLE TO CHECK "YES" FOR ALL STATEMENTS.*

1. The loss of employment was involuntary	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) COBRA continuation coverage.*	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No

***If you checked NO for Statement 3, you may still be eligible. See below for more information**

If your COBRA continuation coverage relates to an involuntary loss of employment prior to or on December 31, 2009, and you were eligible for, but waived COBRA coverage, you still have the right to to revoke your waiver and elect to enroll in COBRA. You must, however, revoke and submit your waiver in writing within the 60-day election period. In this scenario, your COBRA start date may begin on the date your waiver is revoked and therefore, your premium subsidy will not begin until that date. You can contact the EUTF at 586-7390 or toll free at 808-295-0089 or at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813 or go to our website at www.eutf.hawaii.gov for more information.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature _____ Date_____

Type or print name:_____ Relationship to Employee:

FOR EMPLOYER VALIDATION

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual was not enrolled in a health benefit plan when terminated.	☐

4. Other (please explain)

Signature of employer:

Signature _____ Date_____

Type or print name:_____	Position Title_____
Telephone Number:_____	E-mail address:_____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with you COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual to the EUTF at P.O. Box 2121, Honolulu HI 96805 or you can deliver it to our office at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813.

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions under ARRA." For more detailed information, please access our website at www.eutf.hawaii.gov.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL (continued)

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name	Date of Birth	Relationship	SSN
a.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
b.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
c.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
d.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
e.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

NOTE: If there are more dependents, please make a copy of this page and complete it for your additional dependents.